U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 29Nov2001

Case No: 2001-BLA-0452

In the Matter of

CLYDE C. DARNELL,
Claimant

v.

CHEYENNE ELKHORN COAL COMPANY, INCORPORATED,
Employer,

and

FRONTIER INSURANCE COMPANY,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:

Randy G. Clark, Esquire
For the claimant

Richard H. Risse, Esquire
For the employer

Anne T. Knauff, Esquire
For the Director

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER — DENYING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq*. (the Act). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201 (1996).

On February 8, 2001, this case was referred to the Office of Administrative Law Judges for a formal hearing. (DX27). Following proper notice to all parties, a hearing was held on August 28, 2001 in Prestonsburg, Kentucky. The Director's exhibits were admitted into evidence pursuant to 20 C.F.R. § 725.456, and the parties had full opportunity to submit additional evidence and to present closing arguments or post-hearing briefs.

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. They also are based upon my observation of the demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to DX, CX, and EX refer to the exhibits of the Director, claimant, and employer, respectively. The transcript of the hearing is cited as "Tr." and by page number.

ISSUES

The following issues remain for resolution:

1. whether the miner has pneumoconiosis as defined by the Act and regulations;

2. whether the miner's pneumoconiosis arose out of coal mine employment;

3. whether the miner is totally disabled; and

4. whether the miner's disability is due to pneumoconiosis?[1]

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

The claimant, Clyde C. Darnell, was born on August 19, 1950. Mr. Darnell married Ruby June Chaney on April 7, 1972, (DX8) and they reside together. They had no children who were under eighteen or dependent upon them at this time this claim was filed.

In claimant's initial filing, he complained of shortness of breath and a constant cough. (DX1). Claimant has smoked for approximately twenty years; however, he claims to have only smoked one to two cigarettes per day. Claimant eventually ended his mining employment due to a back injury suffered on the job.

Mr. Darnell filed his application for black lung benefits on May 10, 2000. (DX1). The Office of Workers' Compensation Programs awarded benefits on the claim on August 25, 2000, (DX11) and, after reviewing additional evidence, affirmed its award on December 21, 2000. (DX24). Pursuant to employer's and carrier's request for a formal hearing, (DX25) the case was transferred to the Office of Administrative Law Judges for a formal hearing. (DX27).

Medical Evidence

A. X-ray reports

Exhibit	**Date of X-ray**	**Date of Reading**	**Physician/ Qualifications**	**Interpretation**
EX1	02/05/99	02/05/99	West	The diaphragms are somewhat flattened and this may reflect changes of COPD, which clinical correlation would discriminate.
DX 21	04/20/00	11/17/00	Wiot/B/BCR/C	Negative

[1]Employer also challenged the retroactive application of the recently enacted regulations. Although the employer's challenge appears to have been answered by *National Mining Association v. Chao*, 160 F. Supp.2d 47 (D.D.C. 2001), these issues are preserved for appeal.

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX9	5/31/00	5/31/00	Younes/B[2]	Completely Negative
DX10	5/31/00	6/19/00	Sargent/BCR/B	Negative
DX19	9/20/00	9/20/00	Baker/B/BCPD[3]	1/0 pneumoconiosis
DX20	10/12/00	10/12/00	Dahhan/B/BCPD	Completely negative.
DX20	10/12/00	10/21/00	Wheeler/B/BCR[4]	Subtle areas of decreased upper lung markings compatible with emphysema. Negative for pneumoconiosis.
DX20	10/12/00	11/03/00	Wiot/B/BCR/C[5]	Negative.
DX21	10/12/00	11/14/00	Perme/B/BCR	Negative.
DX22	09/20/00	11/28/00	Perme/B/BCR	Negative.

[2]When evaluating interpretations of miners' chest x-rays, an administrative law judge may assign greater evidentiary weight to readings of physicians with superior qualifications. 20 C.F.R. § 718.202(a)(1); *Roberts v. Bethlehem Mines Corp.*, 8 BLR 1-211, 1-213 (1985). The Benefits Review Board and the United States Court of Appeals for the Sixth Circuit have approved attributing more weight to interpretations of "B" readers because of their expertise in x-ray classification. *See Warmus v. Pittsburgh & Midway Coal Mining Co.*, 839 F.2d 257, 261 n.4 (6th Cir. 1988); *Meadows v. Westmoreland Coal Co.*, 6 BLR 1-773, 1-776 (1984). A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51(b)(2). Interpretations by a physician who is a "B" reader and is certified by the American Board of Radiology may be given greater evidentiary weight than an interpretation by any other reader. *See Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993); *Sheckler v. Clinchfield Coal Co.*, 7 BLR 1-128, 1-131 (1984).

[3] Board certified sub-specialty in pulmonary disease.

[4] Board certified radiologist.

[5] This is the highest qualification available to an x-ray reader and it is a closed classification. The group of C-readers designates only those highly regarded individuals who developed the widely used ILO-U/C classification system for classifying x-rays. It is rare to encounter a C-reader in our black lung cases. *Alley v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983).

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX22	10/12/00	11/23/00	Spitz/B/BCR	Negative.
DX23	10/12/00	12/11/00	Shipley/B/BCR	Negative.
DX23	09/20/00	12/11/00	Shipley/B/BCR	Negative.
CX1	01/17/01	01/17/01	Poulus	COPD

B. Pulmonary Function Studies

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1 / FVC	Tracings	Comments
DX9 5/31/00	Younes	49/69.5 in.	2.42*	5.12*	------	0.47*	3	Cooperation and comprehension good.
DX9 5/31/00	Younes	49/69.5 in.	1.93	4.44	49.85	0.43	3	
DX19 9/20/00	Baker	50/69.0 in.	1.57	4.05	52	0.39		Severe obstructive ventilatory defect
DX20 10/12/00	Dahhan	50/69.0 in.	1.99	3.68	-----	0.54		Cooperation good. Comprehension good.
DX20 10/12/00	Dahhan	50/69.0 in.	2.15*	3.78*	-----	0.57*		
CX1 1/23/01	Mettu	50/71.0 in.	1.98	3.79	58	0.52	1	Patient understood test and cooperated well. Patient declined to try lung volume test again

*denotes testing after administration of bronchodilator

C. Arterial Blood Gas Studies

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise	Comments
DX9	5/31/00	Younes	38.4	71.3	Resting	n/a
DX19	9/20/00	Baker	39	71	n/a	Mild resting arterial hypoxemia
DX20	10/12/00	Dahhan	41.6	75.0	Resting	n/a
DX20	10/12/00	Dahhan	40.5	73.4	Exercise	Exercise stopped because of back pain.
CX1	01/23/01	Mettu	39.2	91.5	n/a	n/a

D. Narrative Medical Evidence

Dr. Maan Younes examined claimant on May 31, 2000. (DX 9) The physician submitted claimant to a chest x-ray, an arterial blood gas test, and a pulmonary function test. Dr. Younes recorded a coal mine employment history of twenty-nine years. The doctor noted that the claimant had a history of chronic bronchitis and a family history of emphysema. The doctor also recorded a smoking history of approximately thirty years, one cigarette per day. The doctor's cardiopulmonary diagnoses were chronic obstructive pulmonary disease and chronic bronchitis. Doctor Younes concluded that the primary etiology of both cardiopulmonary problems was smoking and the secondary etiology of the problems was occupational dust exposure. In response to a question posing whether the claimant has an occupational lung disease cause by his employment in the coal mines, the doctor said yes, "since he has severe COPD which was partially caused by occupational dust exposure." The doctor rated the claimant's level of impairment as "severe obstructive pulmonary impairment with significant improvement with bronchodilators." The doctor surmised that the cause of the impairment was identical to the cause of the claimant's cardiopulmonary problems: primarily, smoking and, secondarily, occupational dust exposure. In another section of his medical opinion, the doctor listed the occupational dust exposure as a "contributing factor" to the impairment, though tobacco smoking was the primary cause of the impairment. The doctor concluded that the claimant did not have the respiratory capacity to perform the work of a coal miner or perform comparable work in a dust-free environment because of the claimant's secondary to severe obstructive impairment.

Dr. Glen Ray Baker, Jr., board-certified in pulmonary disease and a "B" reader, examined the claimant on September 20, 2000. (DX 19). The doctor recorded 29 years of coal mine employment and a smoking history of 18-20 years of 1 or 2 cigarettes per day. The doctor recorded that the claimant complained of difficulty with his breathing over the past 10 years with symptoms of cough, sputum production, and wheezing. The claimant claimed that his breathing condition worsened in hot, humid weather. The physician noted that claimant reported he could only walk 30-40 yards before he had to stop and catch his breath. After examining the claimant and evaluating claimant's chest x-ray, pulmonary function test, and arterial blood gas results, the doctor opined that the claimant has a Class IV impairment with the FEV1 less than 40% of predicted value. Also, "[p]atient has a second impairment based on Table 10, Page 164, Chapter Five, Guides to the Evaluation of Permanent Impairment, Fourth Edition, which states although a pneumoconiosis may cause a physiological impairment, its presence usually requires the patient's removal from the dust causing the condition. This would imply the patient to be 100% occupationally disabled." Doctor Baker diagnosed coal workers' pneumoconiosis based on abnormal x-rays and a significant history of dust exposure; mild resting arterial hypoxemia based on arterial blood gas analysis; chronic obstructive airway disease with a severe obstructive ventilatory defect based on pulmonary function testing; and chronic bronchitis based on claimant's history. As to the causation of claimant's condition, the doctor stated that the claimant's disease was the result of exposure to coal dust, citing claimant's abnormal x-rays, a significant history of dust exposure, and no other condition to account for these x-ray changes. Also, Dr. Baker found that, within reasonable medical probability, any pulmonary impairment is the result of exposure to coal dust in the severance of processing coal, citing patient's minimal smoking history and severe obstructive airway disease. The doctor stated, "It is thought that the coal dust is related at least in part, if not significantly so, to his pulmonary impairment."

Dr. A. Dahhan examined claimant on October 12, 2000. (DX20). Dr. Dahhan recorded a 28-year coal mine employment history and a 30-year smoking history, smoking a pack per week. The doctor noted that claimant has a history of daily cough with productive clear sputum but no hemoptysis. The claimant also attested to wheezing and dyspnea on exertion. The doctor opined that the claimant's carboxyhemoglobin level was 9.8%, indicating an individual smoking over two packs per day. After administering pulmonary function tests, the doctor evaluated the results and stated, "Overall, the studies were consistent with a partially reversible obstructive ventilatory defect with no restrictive ventilatory abnormality." The doctor further opined:

In conclusion, based on my examination of Mr. Darnell and my review of his medical records..., within a reasonable degree of medical certainty, the following conclusions can be made:

> 1. There is insufficient objective date to justify the diagnosis of coal workers' pneumoconiosis based on the obstructive abnormalities on clinical examination of the chest, obstructive

> abnormalities with response to bronchodilator therapy on pulmonary function testing, adequate blood gas exchange mechanisms at rest and after exercise and negative x-ray radiological data for the presence of coal workers' pneumoconiosis.
>
> 2. Mr. Darnell has a partially reversible obstructive ventilatory defect based on the pulmonary function studies and the clinical examination of the chest as reported by myself and Dr. Baker.
>
> 3. From a respiratory standpoint, Mr. Darnell does not retain the physiological capacity to perform moderate to heavy manual labor because of his obstructive ventilatory defect.
>
> 4. Mr. Darnell's obstructive ventilatory defect did not result from coal dust exposure or coal workers' pneumoconiosis. He has not had any exposure to coal dust since October of 1998, a duration of absence sufficient to cause cessation of any industrial bronchitis that he may have had. Also, his obstructive ventilatory defect demonstrates response to bronchodilator therapy during testing, a finding that is inconsistent with the permanent adverse affects [sic] of coal dust on the respiratory system.
>
> ....
>
> 6. I find no evidence of pulmonary impairment and/or disability in Mr. Darnell's case caused by, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis. He has a partially reversible obstructive ventilatory defect, which has resulted from his previous smoking habit and is contributed to by his hyperactive airway disease or bronchial asthma since it demonstrates response to bronchodilator therapy. None of these conditions are caused by, contributed, related to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

(DX20).

In a February 26, 2001 medical opinion, Dr. Dahhan echoed his previous conclusions. (EX4). Dr. Dahhan concluded that: 1) there is insufficient data to justify the diagnosis of coal workers' pneumoconiosis; 2) claimant has chronic obstructive lung disease; 3) claimant, because

of his chronic obstructive lung disease, is rendered unable from a respiratory standpoint to return to his previous coal mining work or job of comparable physical demand; 4) claimant's obstructive lung disease has resulted from his lengthy smoking habit; and 5) claimant's obstructive airway disease was not caused by, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis. (*Id.*)

Dr. Dahhan's deposition was taken on August 13, 2001. (EX7). The doctor's testimony corroborated with his written medical opinions. The doctor again concluded:

> To summarize, I concluded this individual has respiratory impairment mild to moderate in nature, has response to bronchodilator therapy associated with negative chest x-ray, and being treated with bronchodilator therapy by his treating physician. I attributed the respiratory impairment to the individual's smoking habit that has shown conflict between the information he provided me and the objective data I have, and concluded that he has no respiratory impairment due to coal mine employment.

(*Id.*).

Dr. R. V. Mettu, whose credentials are not of record, examined the claimant on an unspecified date. (CX 1). Citing patient's history, chest x-ray, blood gases, and pulmonary function studies, the doctor diagnosed "COPD, moderate to severe." Upon review of simply the pulmonary function tests, the doctor stated, "Moderately severe obstructive airway disease with decreased MVV. Lung volumes are consistent with obstructive airway disease. DLCO [diffusion capacity of carbon monoxide] is moderately decreased."

Dr. Peter G. Tuteur, a non-examining physician, submitted a comprehensive medical opinion regarding claimant on February 20, 2001. (EX3). The doctor's opinion was drawn from the following medically relevant data: 1) medical reports prepared by Drs. Younes, Baker, and Dahhan; 2) graphic and numerical data associated with three separate pulmonary function studies in May, September, and October 2000; 3) thirteen chest radiographic reports prepared by ten different reviewers concerning examinations performed on five different dates; and 4) reports of a CT scan of the thorax performed on October 12, 2000. After an exhaustive recitation of claimant's employment and smoking history, in addition to a comprehensive review of the preceding medical data, Dr. Tuteur opined:

> Based on this review, there is no convincing information to indicate the presence of clinically significant, physiologically significant, or radiographically significant coal workers'

pneumoconiosis. There are convincing data to support the diagnosis of partially reversible chronic obstructive pulmonary disease associated with both chronic bronchitis and emphysema. Cigarette smoking would be a most common etiology of such a clinical picture. In this case, though Mr. Darnell smoked cigarettes for 30 years, he reports smoking only a few cigarettes daily. This subjective report is inconsistent with the objective measurement of carboxyhemoglobin at 9.8% (normal less than 2%) at a time when he expresses the opinion that he has discontinued cigarette smoking. Other potential etiologies include alpha-1 antitrypsin deficiency (an inherited form of emphysema). It is noted that Mr. Darnell's brother is reported to have emphysema. Coal mine dust exposure can result in the symptoms of chronic bronchitis and airflow obstruction, but almost never is associated with bullous emphysema unless progressive massive fibrosis is present. There is not a shred of evidence or opinion to indicate that progressive massive fibrosis is present. It is the combination of this variable airflow obstruction and the severe symptoms and limitations associated with his back injury that render Mr. Darnell disabled from performing the work of a coal miner or work requiring similar effort.

. . . . Clearly Mr. Darnell has exercise intolerance. It is exercise intolerance or breathlessness that is a quintessential clinical feature of symptomatic coal workers' pneumoconiosis. Yet, this clinical picture is nonspecific consistent with virtually any primary pulmonary, cardiac, or musculoskeletal injury. . . . . The musculoskeletal injury and its sequelae are carefully documented in the record and clearly is responsible for his exercise intolerance.

. . . .

Based on the totality of all available medical data, it is with reasonable medical certainty that Mr. Clyde Darnell does not have clinically significant, physiologically significant, or radiographically significant coal workers' pneumoconiosis or any other coal mine dust-induced disease process. He does have a primary pulmonary process. That process is chronic obstructive pulmonary disease manifested both by chronic bronchitis and emphysema. The most common cause of such a condition is the chronic inhalation of

> tobacco use . . . . [W]ith reasonable medical certainty, this degree of chronic obstructive pulmonary disease was not caused by, was not aggravated by, and was not influenced by the chronic inhalation of coal mine dust or the development of coal workers' pneumoconiosis.

Dr. Tuteur further opined that the most significant health problem facing the claimant was his lower back injury, which the doctor found in no way connected to the claimant's coal mine employment or the development of pneumoconiosis. The doctor concluded his opinion:

> [I]t is with reasonable medical certainty that Mr. Darnell does not have clinically significant, physiologically significant, or radiographically significant coal workers' pneumoconiosis or any other coal mine dust-induced disease process. His respiratory or pulmonary impairment, moderately and partially reversibly obstructed, did not arise out of his work in the coal mine dust industry or as a result of coal workers' pneumoconiosis.
>
> Mr. Darnell is totally and permanently disabled. His disability is not due to coal workers' pneumoconiosis or any other coal mine dust-induced disease process. It is predominantly due to the sequelae of his low back injury.

Dr. Tuteur was deposed on August 14, 2001, and his testimony was entered as part of the record. (EX6). The doctor's testimony reiterated his written opinion. Dr. Tuteur's medical opinion remained the same.

> I could say with reasonable medical certainty that in this case Mr. Darnell's chronic obstructive pulmonary disease with its appropriate clinical symptomatology, its consistent and typical physical exam, its objective measurement of air flow obstruction by pulmonary function testing and the confirmatory radiographic studies is due to the chronic inhalation of tobacco smoke not coal mine dust.

(*Id.*)

Dr. Lawrence Repsher examined the claimant's medical records and issued a medical opinion on March 13, 2001. After a recitation of the relevant test results and other medical opinions, Dr. Repsher stated the following conclusions in response to questions posed to him by employer's counsel:

> 1. Mr. Darnell does not have coal workers pneumoconiosis or any other coal mine dust induced lung disease.
>
> 2. Mr. Darnell's respiratory impairment is only modest and is related solely to his long, heavy and probably continued cigarette smoking habit, and not at all related to the inhalation of coal dust.
>
> 3. I do not believe that Mr. Darnell is totally and permanently disabled from a respiratory point of view. An FEV1 of 2.42 is clearly sufficient for him to be able to comfortably continue in his previous work as a coal mine superintendent. It may be that Mr. Darnell is totally and permanently disabled as a result of his back injury.

(EX5).

Dr. Repsher was deposed on August 14 , 2001. (EX8). The doctor's testimony reiterates his written testimony.

DISCUSSION AND APPLICABLE LAW

Because claimant filed his application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. Under this part of the regulations, claimant must establish by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. Failure to establish any of these elements precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-112 (1989).

Pneumoconiosis and Causation

Under the Act, "'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Under section 718.202(a)(1), a finding of pneumoconiosis may be based upon

x-ray evidence. The record contains fourteen interpretations of six chest x-rays. Of these interpretations, eleven were negative for pneumoconiosis, one was positive, and two expressed no definitive conclusions as to the existence of pneumoconiosis. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. As noted above, I also may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP*, 12 BLR 1-6 (1988); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc).

Dr. Glen Baker was the only physician to find pneumoconiosis. (DX19). The doctor came to his conclusion after reviewing an x-ray taken on September 20, 2000. Drs. Perme and Shipley also reviewed the same x-ray, both concluding that the radiograph was negative for pneumoconiosis. (DX22,23). Drs. Perme and Shipley are board-certified radiologists and "B" readers, while Dr. Baker is only a "B" reader. Greater weight may be accorded the x-ray interpretation of a dually-qualified (B-reader and board-certified) physician over that of a board-certified radiologist. *Herald v. Director, OWCP*, BRB No. 94-2354 BLA (Mar. 23, 1995)(unpublished). The Board has held that it is also proper to credit the interpretation of a dually qualified physician over the interpretation of a B-reader. *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). *See also Roberts v. Bethlehem Mines Corp*., 8 B.L.R. 1-211 (1985) (weighing evidence under Part 718). Considering the superior qualifications of Drs. Perme and Shipley, I accord greater weight to their interpretations of the September 20, 2000 x-rays than the interpretation of Dr. Baker.

Ignoring interpretations not expressing an opinion as to the presence of pneumoconiosis, all other x-ray interpretations were negative for pneumoconiosis. Because the negative readings constitute the majority of interpretations and are verified by more, highly-qualified physicians, I find that the x-ray evidence is negative for pneumoconiosis.

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. This section is inapplicable herein because the record contains no such evidence.

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Because none of the above presumptions applies to this claim, claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides the fourth and final way for a claimant to prove that he has pneumoconiosis. Under section 718.202(a)(4), a claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis. Although the x-ray evidence is negative for pneumoconiosis, a physician's reasoned opinion may support the presence of the disease if it is supported by adequate rationale besides a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 1-22, 1-24 (1986). The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 BLR 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms and patient's history. *See Hoffman v. B & G Construction Co.*, 8 BLR 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 BLR 1-295 (1984); *Buffalo v. Director*, OWCP, 6 BLR 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp*., 2 BLR 1-130 (1979). A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*. The determination that a medical opinion is "reasoned" and "documented" is for this Court to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc).

In earlier case law, the Board held that an administrative law judge may accord less weight to a consulting or non-examining physician's opinion on grounds that he or she does not have first- hand knowledge of the miner's condition. *Bogan v. Consolidation Coal Co.*, 6 B.L.R. 1-1000 (1984). *See also Cole v. East Kentucky Collieries*, 20 B.L.R. 1-51 (1996) (the administrative law judge acted within his discretion in according less weight to the opinions of the non-examining physicians; he gave their opinions less weight, but did not completely discredit them). A non-examining physician's opinion may constitute substantial evidence, however, if it is corroborated by the opinion of an examining physician or by the evidence considered as a whole. *Newland v. Consolidation Coal Co.*, 6 B.L.R. 1-1286 (1984); *Easthom v. Consolidiation Coal Co.*, 7 B.L.R. 1-582 (1984). Indeed, in *Collins v. J & L Steel (LTV Steel)*, 21 B.L.R. 1-182 (1999), the Board cited to the Fourth Circuit's decision in *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438 (4th Cir. 1997) and held that it was error for the administrative law judge to discredit a physician's opinion solely because he was a "non-examining physician." Also, in *Chester v. Hi-Top Coal Co.*, 22 B.L.R. 1-___ (2001), the Board cited to *Millburn Colliery Co. v. Hicks*, 138 F.3d 524 (4th Cir. 1998) to hold that an administrative law judge may not discredit a medical opinion solely because the physician did not examine the claimant. *But see Sewell Coal Co. v. O'Dell*, Case No. 00-2253 (4th Cir. July 26, 2001) (unpub.) (citing to *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 440 (4th Cir. 1997) to hold that opinions of examining physicians, although not necessarily dispositive, deserve special consideration).

There are six medical opinions in the record, consisting of reports by Drs. Younes, Baker, Dahhan, Mettu, Tuteur, and Repsher. Each will be discussed separately.

Dr. Younes's examination of claimant consisted of an array of tests which adequately document his exposure and knowledge of the claimant's condition. The doctor's opinion, however, is less than clear as to how the results of the individual tests the doctor subjected the claimant to figured into the physician's final conclusions regarding the medical condition of the claimant. Dr. Younes does not use the word "pneumoconiosis" in his medical opinion, citing only claimant's chronic obstructive pulmonary disease caused, primarily, by tobacco use and, secondarily, by occupational dust exposure. In light of the lack of clear reasoning contained in Dr. Younes's opinion, I accord it less probative weight on the existence of pneumoconiosis. Despite its deficiencies, however, the doctor's medical opinion is adequately documented and entitled to some probative weight on the issue of pneumoconiosis.

Dr. Baker's medical opinion relies on chest x-ray evidence, pulmonary function testing, and arterial blood gases. Dr. Baker opined that claimant's September 20, 2000 x-ray was positive for pneumoconiosis, 1/0. The results of the other tests rendered conclusions that the claimant suffered from mild resting arterial hypoxemia and a chronic obstructive airway disease with a severe obstructive ventilatory defect, but not pneumoconiosis. When citing the etiology of his diagnosis of pneumoconiosis, Dr. Baker wrote, "based on abnormal x-rays and significant history of dust exposure." Section 718.202(a)(4) states that a sound medical judgment as to pneumoconiosis may be based on "objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, *and medical and work histories*." (Emphasis added). Thus, Dr. Baker's reliance on the x-ray evidence, as he interpreted it, and the claimant's work history of dust exposure is clearly allowable under the applicable regulation. As Dr. Baker has adequately documented the claimant's work history and is a "B" reader, entitling his x-ray interpretation to probative weight, I find his conclusion of pneumoconiosis entitled to probative weight.

I find Dr. Dahhan's medical opinions extremely well-documented and reasoned. (DX20; EX4). The doctor reached his medical opinion by submitting claimant to an electrocardiogram, pulmonary function test, arterial blood gas test, and a chest x-ray and considering an October 12, 2000 high resolution CT scan read by Dr. Wheeler. Dr. Dahhan clearly and thoroughly concludes that the claimant does not suffer from pneumoconiosis, plainly explaining the bases for his medical conclusions. Furthermore, Dr. Dahhan's deposition testimony adequately supports his written medical conclusions, not deviating from his previous opinions. Considering the depth of examination and the thoroughness of Dr. Dahhan's opinion, I find his opinion extremely probative on the issue of the existence of pneumoconiosis, and I accord it substantial weight on the issue.

Dr. Mettu submitted claimant to a battery of tests, including a pulmonary function test, arterial blood gas test, and a chest x-ray. The performance of these tests is well-documented; however, the doctor's medical opinion is not well-reasoned. The doctor states his medical impression is "COPD, moderate to severe." He, however, does not provide the bases for his conclusion. Beyond citing a January 2001 chest x-ray read by Dr. Poulos and abnormal pulmonary function study results, the doctor provides no reasoning or explanation as to how the results of the test lead to his conclusion. Thus, I find the doctor's opinion entitled to less probative weight on the issue of the existence of pneumoconiosis .

I accord Dr. Tuteur's medical opinion great probative weight on the issue of the existence of pneumoconiosis due to his documentation, analytical thoroughness, and credentials. The doctor's opinion covers every relevant medical test performed on the claimant, and, in minute detail, analyzes the results. The doctor's opinion is clear and thorough in that he can find no evidence of pneumoconiosis. Though Dr. Tuteur was not an examining physician, the unparalleled thoroughness of his well-documented and reasoned opinion entitles it to substantial probative weight. A non-examining physician's opinion may constitute substantial evidence if it is corroborated by the opinion of an examining physician or by the evidence considered as a whole. *Newland v. Consolidation Coal Co.*, 6 B.L.R. 1-1286 (1984); *Easthom v. Consolidiation Coal Co.*, 7 B.L.R. 1-582 (1984). The conclusions that Dr. Tuteur reaches are more than adequately supported by the findings of Dr. Dahhan. Furthermore, the doctor's written opinion is bolstered by his deposition testimony which corroborated his written opinion in all details.

Similar to Dr. Tuteur, I accord Dr. Repsher's opinion substantial probative weight on the issue of pneumoconiosis. Dr. Repsher's opinion is clear and thoroughly researched. His opinion is unequivocal in its position that the claimant does not suffer from pneumoconiosis. Again, although Dr. Repsher did not examine the claimant directly, his opinion is corroborated by the opinion of Dr. Dahhan. *Newland v. Consolidation Coal Co.*, *supra*; *Easthom v. Consolidiation Coal Co.*, *supra*. Thus, I grant Dr. Repsher's opinion substantial probative weight.

On balance, the great weight of the medical narrative evidence does not establish the existence of pneumoconiosis. Drs. Tuteur, Repsher, and Dahhan present thorough and well-reasoned opinions, the probative value of which outweigh any weight accorded to the opinions of Drs. Younes, Baker, and Mettu. As the evidence does not establish the existence of pneumoconiosis, this claim cannot succeed.

Total Disability

A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204 (b)(1). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total

disability. *See Beatty v. Danri Corp.*, 16 BLR 1-11, 1-15 (1991). Section 718.204(b)(2) provides several criteria for establishing total disability. Under this section, I must first evaluate the evidence under each subsection and then weigh all of the probative evidence together, both like and unlike evidence, to determine whether claimant has established total respiratory disability by a preponderance of the evidence. *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195, 1-198 (1987).

Under Sections 718.204(b)(2)(i) and (b)(2)(ii), total disability may be established with qualifying pulmonary function studies or arterial blood gas studies.[6] The record contains both pulmonary function studies and arterial blood gas studies. Each will be discussed separately.

Pulmonary Function Studies

The pulmonary function study measures obstruction in the airways of the lungs. The greater the resistance to the flow of air, the more severe any lung impairment. A pulmonary function study does not indicate the existence of pneumoconiosis; rather, it is employed to measure the level of the miner's disability. The regulations require that this study be conducted three times to assess whether the miner exerted optimal effort among trials, but the Board has held that a ventilatory study which is accompanied by only two tracings is in "substantial compliance" with the quality standards. *Defore v. Alabama By-Products Corp.*, 12 B.L.R. 1-27 (1988). An administrative law judge may infer, in the absence of evidence to the contrary, that the ventilatory results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984).

All ventilatory studies of record, both pre-bronchodilator and post- bronchodilator, must be weighed. *Strako v. Ziegler Coal Co.*, 3 B.L.R. 1-136 (1981). To be qualifying, the FEV1 as well as the MVV or FVC values must equal or fall below the applicable table values. *Tischler v. Director, OWCP*, 6 B.L.R. 1-1086 (1984). In addition, the results of a study cannot be "rounded off" to render it qualifying. *Bolyard v. Peabody Coal Co.*, 6 B.L.R. 1-767 (1984); *Sexton v. Peabody Coal Co.*, 7 B.L.R. 1-411, 1-412 n. 2 (1984).

As an individual ages, his or her lung capacity lessens. Differences in lung volume have also been noted between women and men of the same age and height. As a result, tables of data based upon the miner's age, height, and gender are used to determine whether the study has produced qualifying results.

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[6]A "qualifying" pulmonary function study or arterial blood gas study yields values that are equal to or less than the applicable table values found in Appendices B and C of Part 718. *See* 20 C.F.R. § 718.204(b)(2)(i) and (ii). A "non-qualifying" test produces results that exceed the table values.

The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1- 221 (1983). *See also Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995) (the fact-finder erred in failing to resolve height discrepancies in the record particularly where the discrepancies affected whether the tests were qualifying). The record in the instant case contains height discrepancies regarding the claimant. Two doctors list the claimant's height as 69.0 inches; one doctor at 69.5 inches; and a third doctor at 71.0 inches. A simple averaging of the numbers results in a claimant height of 69.625 inches. As the closest height value in the applicable tables is 69.7 inches, I find that for pulmonary function test result analysis, the claimant's height is 69.7 inches.

A qualifying FEV1 value for a 50-year old male, 69.7 inches tall is 2.19. With the exception of one pulmonary function test, performed after an administration of a bronchodilator, every pulmonary function test performed on claimant yielded qualifying results.

A qualifying FVC value for a 50-year old male, 69.7 inches tall is 2.76. No pulmonary function test performed on the claimant yielded qualifying results.

A qualifying MVV value for a 50-year old male, 69.7 inches tall is 88. Every pulmonary function test reporting MVV values yielded qualifying MVV results.

A qualifying FEV1/FVC value for a 50-year old male, 69.7 inches tall is 0.55 or 55%. With the exception of one pulmonary function test, performed after an administration of a bronchodilator, every pulmonary function test performed on claimant yielded qualifying FEV1/FVC results.

Thus, every pre-bronchodilator pulmonary function test performed on the claimant resulted in qualifying values. This result will be weighed together with other evidence to determine if total disability has been established.

Arterial Blood Gas Studies

A blood gas study is designed to measure the ability of the lung to oxygenate blood. The initial indication of a miner's impairment will most likely manifest itself in the clogging of alveoli, as opposed to airway passages, thus rendering the blood gas study a valuable tool in the assessment of disability.[7] The blood sample is analyzed for the percentage of oxygen (PO2) and the

[7]Alveoli are air sacs which line the lungs in a honeycomb pattern. Oxygen passes through the alveoli into the bloodstream on inspiration and carbon dioxide is released from the bloodstream on expiration. A lower level of oxygen compared to carbon dioxide in the blood indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

percentage of carbon dioxide (PCO2) in the blood. Tables are provided in the regulations for determining whether the study yields qualifying values, thus lending support for a finding that the miner is totally disabled.

No arterial blood gas study resulted in qualifying values. This result will be weighed together with other evidence to determine if total disability has been established.

Section 718.204(b)(2)(iii) provides that a claimant may prove total disability through evidence establishing cor pulmonale with right-sided congestive heart failure. This section is inapplicable to this claim because the record contains no such evidence.

Where a claimant cannot establish total disability under subparagraphs (b)(2)(i), (ii), or (iii), Section 718.204(b)(2)(iv) provides another means to prove total disability. Under this section, total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a respiratory or pulmonary impairment prevents the miner from engaging in his usual coal mine work or comparable and gainful work.

The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 BLR 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms and patient's history. *See Hoffman v. B & G Construction Co.*, 8 BLR 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 BLR 1-295 (1984); *Buffalo v. Director*, OWCP, 6 BLR 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp*., 2 BLR 1-130 (1979). A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*. The determination that a medical opinion is "reasoned" and "documented" is for this Court to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc).

In earlier case law, the Board held that an administrative law judge may accord less weight to a consulting or non-examining physician's opinion on grounds that he or she does not have first-hand knowledge of the miner's condition. *Bogan v. Consolidation Coal Co.*, 6 B.L.R. 1-1000 (1984). *See also Cole v. East Kentucky Collieries*, 20 B.L.R. 1-51 (1996) (the administrative law judge acted within his discretion in according less weight to the opinions of the non-examining physicians; he gave their opinions less weight, but did not completely discredit them). A non-examining physician's opinion may constitute substantial evidence, however, if it is corroborated by the opinion of an examining physician or by the evidence considered as a whole.

Newland v. Consolidation Coal Co., 6 B.L.R. 1-1286 (1984); *Easthom v. Consolidiation Coal Co.*, 7 B.L.R. 1-582 (1984). Indeed, in *Collins v. J & L Steel (LTV Steel)*, 21 B.L.R. 1-182 (1999), the Board cited to the Fourth Circuit's decision in *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438 (4th Cir. 1997) and held that it was error for the administrative law judge to discredit a physician's opinion solely because he was a "non-examining physician." Also, in *Chester v. Hi-Top Coal Co.*, 22 B.L.R. 1-___ (2001), the Board cited to *Millburn Colliery Co. v. Hicks*, 138 F.3d 524 (4th Cir. 1998) to hold that an administrative law judge may not discredit a medical opinion solely because the physician did not examine the claimant. *But see Sewell Coal Co. v. O'Dell*, Case No. 00-2253 (4th Cir. July 26, 2001) (unpub.) (citing to *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 440 (4th Cir. 1997) to hold that opinions of examining physicians, although not necessarily dispositive, deserve special consideration).

There are five medical opinions in the record, consisting of reports by Drs. Younes, Baker, Dahhan, Tuteur, and Repsher. Each will be discussed separately.

Dr. Younes opined that claimant did not have the capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment because of "secondary to severe obstructive impairment." (DX9). When prompted to provide detailed rationale, including objective and clinical findings to support his conclusion, the doctor does not provide explicit rationale. It is clear that the doctor performed an x-ray evaluation, a pulmonary function test, an arterial blood gas test, however, Dr. Younes does not explicitly draw upon those test results to support and provide reason for his medical conclusions. In light of the lack of clear reasoning contained in Dr. Younes's opinion, I accord it less probative weight on total disability. Despite its deficiencies, however, the doctor's medical opinion is adequately documented and entitled to some probative weight.

Dr. Baker determined that claimant is "100% occupationally disabled." (DX19). The doctor indicated that his conclusions relied upon chest x-ray interpretation, pulmonary function testing, and arterial blood gases. The doctor, however, does not explicitly document how the results of the independent tests formed his medical opinion as to the disability of the claimant. Dr. Baker's opinion, thus, contains only a statement of reliance on certain tests and a bare conclusion. No clear, explicit medical reasoning connects the test results to the conclusion of total disability. In light of the lack of clear reasoning contained in Dr. Baker's opinion, I accord it less probative weight on total disability. Despite its deficiencies, however, the doctor's medical opinion is adequately documented and entitled to some probative weight.

As stated earlier, I find Dr. Dahhan's medical opinions extremely well-documented and reasoned. (DX20; EX4). The doctor reached his medical opinion by submitting claimant to an electrocardiogram, pulmonary function test, arterial blood gas test, and a chest x-ray and considering an October 12, 2000 high resolution CT scan read by Dr. Wheeler. Dr. Dahhan clearly

and thoroughly concludes that the claimant does not retain the physiological capacity to perform moderate to heavy manual labor because of his obstructive ventilatory defect. (DX20). The doctor went on to conclude that the claimant's disability does not have a coal-dust employment etiology. The opinion, however, is unequivocal in its statement that the claimant's respiratory condition prevents him from engaging in his former employment or comparable employment. Furthermore, Dr. Dahhan's deposition testimony adequately supports his written medical conclusions, not deviating from his previous opinions. Considering the depth of examination and the thoroughness of Dr. Dahhan's opinion, I find his opinion particularly probative on the issue of total disability, and I accord it substantial weight on the issue.

I accord Dr. Tuteur's medical opinion great probative weight on the issue of the existence of pneumoconiosis due to his documentation, analytical thoroughness, and credentials. The doctor's opinion covers every relevant medical test performed on the claimant, and, in minute detail, analyzes the results. The doctor's opinion states that "It is the combination of this variable airflow obstruction and the severe symptoms *and* limitations associated with his back injury that render Mr. Darnell disabled from performing the work of a coal miner or work requiring similar effort." (EX3)(emphasis added). "Mr. Darnell is totally and permanently disabled. [His disability] is predominantly due to the sequelae of his low back injury." (*Id.*). Thus, Dr. Tuteur advances that, primarily, a back injury and, secondarily, respiratory obstruction caused the claimant's disability, not solely a respiratory impairment. Though Dr. Tuteur was not an examining physician, the unparalleled thoroughness of his well-documented and reasoned opinion entitles it to substantial probative weight. A non-examining physician's opinion may constitute substantial evidence if it is corroborated by the opinion of an examining physician or by the evidence considered as a whole. *Newland v. Consolidation Coal Co.*, 6 B.L.R. 1-1286 (1984); *Easthom v. Consolidiation Coal Co.*, 7 B.L.R. 1-582 (1984). Dr. Tuteur's conclusion that claimant's respiratory obstruction was *a cause*, but not *the cause*, is corroborated by Dr. Dahhan's opinion. Furthermore, the doctor's written opinion is bolstered by his deposition testimony which corroborated his written opinion in all details.

Similar to Dr. Tuteur, I accord Dr. Repsher's opinion substantial probative weight on the issue of total disability. Dr. Repsher's opinion is clear and thoroughly researched. The doctor unequivocally concludes that the claimant is not totally disabled from a respiratory perspective. "I do not believe that Mr. Darnell is totally and permanently disabled from a respiratory point of view. An FEV1 of 2.42 is clearly sufficient for him to be able to comfortably continue in his previous work as a coal mine employment. It may be that Mr. Darnell is totally and permanently disabled as a result of his back problem." (EX5). Again, although Dr. Tuteur did not examine the claimant directly, his opinion is corroborated by the evidence as a whole. *Newland v. Consolidation Coal Co., supra*; *Easthom v. Consolidiation Coal Co., supra*. Thus, I grant Dr. Repsher's opinion substantial probative weight.

The weight of the medical opinions establish total disability. Drs. Younes, Baker, and Dahhan opine that claimant's respiratory impairment prevents him from performing his usual coal mine work or comparable work. Dr. Tuteur finds total disability and, although he primarily attributes the disability to claimant's back injury, he does cite claimant's respiratory impairment as a contributing factor. Only Dr. Repsher finds no total disability.

The administrative law judge cannot merely weigh like/kind evidence. Specifically, it is error to look at all the pulmonary function studies and conclude that the miner is totally disabled, or to look at all the blood gas studies to conclude that the miner is not totally disabled. The administrative law judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If so, the administrative law judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Troup v. Reading Anthracite Coal Co.*, 22 B.L.R. 1-11 (1999) (en banc); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp*., 9 B.L.R. 1-195, 1-198 (1986). Considering the medical opinions, the pulmonary function tests, and the arterial blood gas results together, I find that the claimant has established total disability. Each pre-bronchodilator pulmonary function test yielded qualifying results and the weight of the medical opinions supported a conclusion of total respiratory disability preventing claimant from performing his usual coal mine work or comparable employment.

Total Disability Due To Pneumoconiosis

As I have found that the claimant has failed to carry his burden of establishing the presence of pneumoconiosis, the claimant cannot demonstrate total disability due to pneumoconiosis.

Conclusion

In sum, the evidence does not establish the existence of pneumoconiosis or a totally disabling respiratory impairment. Accordingly, the claim of Clyde C. Darnell must be denied.

Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the claimant is found to be entitled to benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to claimant for legal services rendered in pursuit of the claim.

ORDER

The claim of Clyde C. Darnell for benefits under the Act is denied.

A
JOSEPH E. KANE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty days from the date of this decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2605, Washington, D.C. 20210.